**West Linn-Wilsonville School District**

# Authorization for Medication Administration by School Personnel

Student
Name:_____DOB:_____Grade:_____

I am giving school personnel permission to administer medications to my child per the following:
Parent or Physician please complete:

**Medication**:_____

**Dose (how much)**:_____
Dosage to be administered at school cannot exceed manufacturer recommendation unless accompanied by a doctors order.

**Route**: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation
Rectal Injectable

**Time to be given at school**:_____

**Reason for Medication**: Check one:
_____Prolonged Seizure
_____Severe Allergic Reaction
_____Severe Hypoglycemic Reaction
_____Other (describe)_____

**Begin Date**_____ **End Date**_____

Expiration date of medication_____

☐ Non-prescription

☐ Please allow my child to self-administer this medication. (refer to district policy on self medication). If prescription, consent of physician is required (See Below)

*ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.*

**Special Instructions:**_____

Tablets requiring cutting should be cut by the parent before being send to school. Liquid medication requires dosage spoons or cut to be supplied by parent

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded. Parent must notify school of any doses of OTC medications that are given prior to the school day to avoid overmedicating the student ( ie. If student takes a pain reliever before coming to school)

Parent/Guardian
Signature:_____Date:_____
(This authorization applies only to this medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

**PHYSICIAN DIRECTION**
(Required in writing or on pharmacy label for all prescription medications).

☐ I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.

☐ Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer).

☐ Special instructions including adverse reactions and action required:_____

_____

_____ _____
Physician's Name (please print/stamp) Address Zip Code

_____ _____ _____
(Physician's Signature) (Phone#) (Effective Date)